



## PAST HISTORY OF ILLNESS and MEDICAL PROBLEMS

**Surgery: List all surgery and approximate dates**

**Other Hospitalizations and dates**



**Broken bones and/or traumatic injuries**  
**Include all car accidents or concussions**

**Major complaints and duration**  
**Example: High Blood Pressure 10 yrs**



### PAST HISTORY

YES	WHEN	YES	WHEN	YES	WHEN
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Neurologic Problem	_____
<input type="checkbox"/> AIDS	_____	<input type="checkbox"/> Epstein Barr	_____	<input type="checkbox"/> Nightmares, frequent	_____
<input type="checkbox"/> Alcohol/Drug problems	_____	<input type="checkbox"/> Fibrocystic breasts	_____	<input type="checkbox"/> Overweight 20#	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Fibroids	_____	<input type="checkbox"/> Pelvic infection	_____
<input type="checkbox"/> Almagams/silver fillings	_____	<input type="checkbox"/> Gallbladder problems	_____	<input type="checkbox"/> Peptic ulcer	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Glasses/contacts	_____	<input type="checkbox"/> Periodontal disease	_____
<input type="checkbox"/> Antibiotics more than once a year	_____	<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Phlebitis	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Gonorrhea	_____	<input type="checkbox"/> Premenstrual tension	_____
<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Prostate problem	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Hearing problem	_____	<input type="checkbox"/> Reactions to vaccinations	_____
<input type="checkbox"/> Back pain/strain	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Root canal	_____
<input type="checkbox"/> Bladder infections	_____	<input type="checkbox"/> Heart problem	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Breast fed	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Breast lump	_____	<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Skin problems	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Hiatal Hernia	_____	<input type="checkbox"/> Sleep disorder	_____
<input type="checkbox"/> Bulimia(self-induced vomiting)	_____	<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> High cholesterol/ triglycerides	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Histoplasmosis	_____	<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Chemical sensitivity	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> Taken steroid (cortisone/prednisone)	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Hypoglycemia	_____	<input type="checkbox"/> Thyroid problems	_____
<input type="checkbox"/> Chronic fatigue	_____	<input type="checkbox"/> Infectious mono.	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Coccidiomycosis	_____	<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/> Tooth problems	_____
<input type="checkbox"/> Colds, frequent	_____	<input type="checkbox"/> Kidney infection	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Urine problems	_____
<input type="checkbox"/> Congenital defect	_____	<input type="checkbox"/> Kidney problem	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Counseling	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Vision problem	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Other problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Menstrual problem	_____		
<input type="checkbox"/> Ear infection	_____	<input type="checkbox"/> Mental illness	_____		
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Migraine	_____		
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Mumps	_____		
		<input type="checkbox"/> Nervous condition	_____		

**PERSONAL HISTORY**

Current medications  
(list all prescription and non prescription)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vitamin and mineral substances  
(type and dosage)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

I am allergic to the following medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have other known allergies to foods, chemicals or inhalants(i.e. pollens, animals,etc) Please list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Lifestyle**

List your favorite food or cravings

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I often eat seconds.  yes  no

To control my weight, I have used:  fasting longer than 1 day

diet pills  self induced vomiting  laxatives

enemas  diuretics(water pills)  health/diet

exercise-  regular,  extreme.  other \_\_\_\_\_

I am now or have been a smoker.  yes  no

How many years have you smoked? \_\_\_\_\_

When did you quit? \_\_\_\_\_

What do you smoke now? \_\_\_\_\_

How much? \_\_\_\_\_

I usually eat  white bread  commercial wheat bread  
 whole grain bread

I usually eat  fresh  frozen  canned vegetables

I usually eat my vegetables  raw  steamed  boiled  
 sautéed

I usually eat  fresh  frozen  canned fruits.

I eat beef or pork  at least once a day  5 times a wk  
 less than three times a week  never

I usually prepare my meat and fish  pan fried  deep fried  
 baked  broiled  bar b qued

I eat refined sugar.  yes  no

My salt use is  none added  light  moderate  
 heavy

I drink  city  well  spring  distilled  filtered water.  
\_\_\_\_\_ ounces/day

I participate in an exercise program.  yes  no

I exercise on a regular basis.  yes  no

I estimate my use of:

coffee: \_\_\_\_\_ cups/day

decaf: \_\_\_\_\_ cups/day

tea: \_\_\_\_\_ cups/day

soda: \_\_\_\_\_ oz-cans/day

I use  beer  wine  "hard" liquor

I consider myself a  non drinker  social drinker  
 heavy drinker  alcoholic  recovering alcoholic

I use  marijuana  other drugs \_\_\_\_\_

I need counseling or medical care to help me control my use of:  alcohol  tobacco  food  drugs

I would like nutritional counseling.  yes  no

I think this is enough exercise.  yes  no

I sleep well.  yes  no

I worry about  money  job  family life  
 relationships  other \_\_\_\_\_

I find my work  too demanding  boring  satisfactory  
 very satisfactory  excellent

My sex life is satisfactory.  yes  no

I do the following for relaxation/recreation:

Activity	Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

My last physical exam was \_\_\_\_\_.

### Life Changes

In the past 12 months, what changes have occurred in your:

#### 1. Personal life

---

---

---

---

#### 2. Family life

---

---

---

---

#### 3. Social Life

---

---

---

---

#### 4. Work Life

---

---

---

---

#### 5. Sex Life

---

---

---

---

I am currently seeing a psychotherapist or other mental health professional.  yes  no

I am currently seeing a chiropractor, osteopath or other physical therapy person.  yes  no

I have been in the military.  yes  no

I have been a victim of:  physical  sexual  
 emotional abuse

In my life, I am safe: Emotionally  yes  no  
Sexually  yes  no Physically  yes  no  
Home  yes  no Work  yes  no  
If not safe at do you have a safe place to go?  Yes  No  
Would you like some assistance?  yes  no

I have been arrested.  yes  no

My spiritual life is satisfactory..  yes  no

I am currently involved in a spiritual program.  yes  no

## Review of Systems

Answer "yes" if you have had these symptoms in the last 6 months.

- Chronic fatigue
- Mood swings
- Chronic depression
- Trembling episodes
- Light-headedness
- Food-craving
- Frequent infection
- Night sweats
- Swollen glands
- Skin rashes
- Chills/ fever
- Change in skin or nails
- Change in wart or mole
- Abnormal bleeding/bruising
- Unusual hair loss/growth
- Change in hair loss/growth
- Irritability
- Restlessness
- Headaches
- Dizziness
- Balance problem
- Head injury
- Seizure/convulsion
- Poor memory
- Difficulty concentrating
- Fainting
- Weakness
- Numbness/tingling
- Blurred vision
- Double vision
- Loss of any vision
- Halos around lights
- Excessive tearing/itching
- Eye pain
- Dark circles under eyes
- Date of last eye exam \_\_\_\_\_
- Loss of hearing
- Ringing or buzzing in ears
- Sinus trouble
- Nosebleed
- Sore throat
- Hoarseness
- Change in voice
- Dental problem
- Dry mouth
- Excessive salivation
- Bleeding gums

- Mouth breather
- Chronic cough
- Bloody/yellow sputum
- Shortness of breath
  - with exertion
  - at night
- Bronchitis
- Chest pain with breathing
- High Blood Pressure
- Chest pain or pressure
  - at rest
  - with exertion
  - with stress
  - with eating
  - down left arm or back
  - accompanied by nausea,
  - sweating, anxiety
- Irregular heartbeat
- Skipped beats
- Palpitations
- Fast heart beat
- Heart murmur
- Swelling feet/legs
- Cold hands/feet
- Leg cramps at night
- Pain or fatigue in legs with exercise
- Burning feet
- Sore legs/feet
- Color change legs/arms
- Pain/discomfort when eating
- Bad teeth
- Belching
- Coating on tongue
- Pain relieved by eating
- Nausea/vomiting
- Trouble with fried foods
- Bloating of the abdomen
- Bowel gas
- Diarrhea
- Constipation
- Black stool
- Clay colored stool
- Mucus in stool
- Hemorrhoids
- Rectal bleeding

- Abdominal pain
- Change in diet
- Pain/burning urination
- Frequent urination
- Urination at night
- Blood in urine
- Foul odor to urine
- Low back pain
- Loss of control/urine

### MEN

- Enlarged prostate
- Decreased urine stream
- Unable to interrupt stream
- Dribbling after urination
- Pus or drainage from penis
- Genital swelling/rash
- Problem with sexual function

### WOMEN

- Last menstrual period \_\_\_\_\_
- Age began menstruation \_\_\_\_\_
- Age at menopause \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- Number of live births \_\_\_\_\_
- Number of abortions/miscarriages \_\_\_\_\_
- Complications of pregnancy
  - Used birth control pills
  - Used IUD
- type: \_\_\_\_\_
- Usual length of cycle: \_\_\_\_\_
- Usual length of period bleeding: \_\_\_\_\_
- Change in cycle
  - Spotting between periods
  - Discomfort with periods
  - Premenstrual tension
  - Vaginal discharge
  - Painful intercourse
  - Itching
  - Self breast exam
  - Lump in breast
  - Would you like to learn self exam?
  - Self vaginal exam
  - Problem with sexual function
  - Abnormal PAP smear
  - Infertility
- Date of last pap smear \_\_\_\_\_

Please continue to next page.

**YES**

- Muscle pain:  
Where: \_\_\_\_\_
- Muscle weakness:  
Where: \_\_\_\_\_
- Joint pain:  
Where: \_\_\_\_\_

**YES**

- Joint pain aggravated by motion
- Joint pain relieved by motion
- Swollen joints
- Stiff joints

**How do you feel when you wake up in the morning?**

**How often do you ordinarily eat (anything) during a 24 hour period?**

**Please add anything that you want to be known, that has not been covered? Perhaps indicate what is/are the most important concern(s) for you.**

***Thank you! This will be reviewed at our initial visit-with the goal of improving YOUR health and sense of wellness!***